2019 Samaritan Vision Plan Benefits

This Plan pays for vision examinations and corrective lenses and frames for you and your enrolled dependents when prescribed by a licensed ophthalmologist or licensed optometrist. The Plan allows you to choose any licensed ophthalmologist, optometrist or optician. However, there is a difference in member cost sharing for participating (in-network) vision providers and non-participating (out-of-network) vision providers.

Benefits	
Deductible Per calendar year	There is no deductible for covered vision services or supplies. Benefits are paid up to the maximum plan allowance limits listed below. These vision care benefits are provided on a calendar year basis.
Eye Examinations	One comprehensive eye exam per calendar year.
Vision Hardware and/or Accessories This is NOT a complete list	The following hardware and/or accessories are covered every 1 calendar year at a combined maximum plan allowance of $175: • Single Vision Lenses • Polycarbonate Lenses • Lined bifocal Lenses • Lined trifocal Lenses • Contact Lenses • Frames • Progressive lenses are covered, if prescribed and billed appropriately by a licensed provider and for a diagnosis not excluded in our plan description

Cost Share	In-network	Out-of-network
Vision Exam	$25 copay	$25 copay, then 70% co-insurance

Limitations and Exclusions	
The vision care benefit will only pay for the items listed above up to the maximum limit per individual and per calendar year.	The following are not covered benefits under this Plan: • Any cost which is in excess of the maximum plan allowance • Medical or surgical treatment of the eyes • Visual fields testing • Contact lens or eyeglass fitting fees • Orthoptics or vision training • Lenticular lenses • Subnormal vision aids • Aniseikonic lenses • High index lenses (other than polycarbonate) • Photochromic, transition and nonprescription tinted lenses • Hardware repairs • Nonprescription or Plano lenses • Extra charges for fashion eyewear features such as blended bifocals, flash coated, oversize lenses, or more than the standard cost for frames. • Duplication or replacement eyeglasses, lenses or frames • Any eye examination required as a condition of employment • Any expense paid in whole or in part by any other provision of the Group Plan provided by your employer • Experimental or investigational vision services are excluded under the same standards as the medical benefits • Services and supplies that are payable under a workers' compensation or occupational disease law